CALIFORNIA MEDICAL ASSOCIATION

NOTICES AND REPORTS

Changes in C.P.S. Procedures

Significant changes in California Physicians' Service have just been effected — incorporating recommendations of C.P.S. Administrative Members during the recent convention in Los Angeles of the California Medical Association.

The revisions are designed to strengthen the operating and financial base of the C.P.S. prepayment plan, to simplify its procedures, and to achieve a position such that the objective of full payments of the C.P.S. fee schedules may be realized.

Nursing and clerical personnel will benefit from a thorough understanding of the changes, and C.P.S. suggests that physicians ask their secretaries and nurses to read this article.

The changes are:

New Billing Form No. 9: A new and simplified Billing Form No. 9 is being put into effect, having been devised and approved by the C.P.S. board of trustees after many months of careful study. Form No. 9 enables the physician member to ask the beneficiary to fill in pertinent membership information, and includes a section in which the member indicates his income status.

C.P.S. officers point out that the bills frequently do not give a complete picture of any special or unusual medical or surgical procedure. In such cases C.P.S. payments are necessarily based on an incomplete report. C.P.S. urges that physicians instruct their office personnel to give complete data in all instances, and suggests that the physician or nurse carefully check the beneficiary's membership number on the C.P.S. card. This, it was pointed out, is of utmost importance because C.P.S. cases are filed numerically and any error may delay payment and cause unnecessary correspondence and telephone calls.

New Income Ceiling: After more than a year of careful study and guided by the expression of the Administrative Members of C.P.S., industrial surveys, and several medical polls, the board of trustees changed the C.P.S. income ceiling to an annual $3,600 gross income to be effective on services performed after August 1, 1949. This change will simplify record-keeping for physician members. As previously mentioned, the new Billing Form No. 9 will require the beneficiary to indicate his income. Experience has proved that many misunderstandings can be avoided if physicians, at the time of the first visit, discuss charges for service with the beneficiary whose income exceeds the $3,600 gross annual income figure. It is of great importance to discuss the probable amount in advance of any service rendered. This, it was pointed out, is vital to the public relations of the physician as well as to the public acceptance of the voluntary health plan movement.

New Physicians' Payment System: Beginning on August 1, 1949, *Northern California* physician members' accounts with C.P.S. will be credited daily with the amount of each claim submitted. At the end of the month one check covering all claims credited during the month, together with the Billing Form No. 9 and an itemized descriptive statement with all items included in the remittance, will be sent to the physician member.

The new system has been made necessary by the huge volume of claims now being paid. An application of mechanical bookkeeping equipment makes this possible, and a representative savings in postage and operational expense will result.

Individual Membership Plan: The C.P.S. individual plan, covering surgical and hospital bills, is being offered throughout *Northern California* (north of and including Fresno County) effective August 1.

In September 1948, this surgical-hospital plan for individuals and their families who were unable to join C.P.S. through group enrollment was offered in Humboldt-Del Norte counties. Wide public acceptance of the new plan, coupled with proof of its financial feasibility, led to extension of this coverage to 17 northeastern counties last May.

The individual membership plan will be extended to Southern California as soon as possible through cooperation with the hospital service of Southern California Blue Cross Hospitalization Plan. When this is done, individuals will have the benefit of C.P.S. protection on a state-wide basis. All requests for information regarding this new coverage are being referred to C.P.S. San Francisco offices, 440 Mission Street.

PART 1—CPS REQUIRES THAT THE PATIENT FILL OUT PART 1

Patient's Full Name (First) PLEASE PRINT (Last) | Age | CPS Group No. | CPS Member No.

Patient's Home Address (Number) (Street) (City)

I CERTIFY THAT MY FAMILY GROSS INCOME LAST YEAR WAS: Check One—OVER $3600.00 ☐ UNDER $3600.00 ☐

I UNDERSTAND MY CONTRACT PROVIDES THAT IF MY FAMILY GROSS INCOME IS OVER THE CPS CEILING, CPS PAYMENT WILL BE APPLIED TO THE PHYSICIAN'S USUAL CHARGE FOR SERVICES. (SEE REVERSE SIDE.)

PATIENT'S SIGNATURE

PART 2 — PHYSICIAN FILLS OUT

New Case ☐
Continued Case ☐
Referred Case ☐

Diagnosis

Surgical Procedures (Fill in dates)

Date

Special Medical Services and Dates

List X-Ray and Laboratory Work Performed in Your **OWN** Office

Enter **ALL VISITS** for services rendered including the first two visits.

Services in Month of:

Enter number of calls under day of month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Office Visit																															
Home Day—Before 11 PM																															
Home Night—After 11 PM																															
Hospital Visit																															

Physician's Name CPS Physician No.

Address (Number) (Street) (City)

PHYSICIAN ATTENTION: PLEASE DESCRIBE BY LETTER **UNUSUAL CASES** SO THAT MEDICAL COMMITTEE MAY EVALUATE FEE.

Date mailed to CPS

Original: Send this copy with yellow duplicate to **California Physicians' Service** before the 15th of month following service. Bills received more than 6 months after month of service will not be honored for payment.

Form 9

(Above is replica of front of new Form 9; reverse side is duplicated below.)

IN ORDER TO PROPERLY IDENTIFY YOUR COVERAGE, C.P.S. REQUIRES THAT YOU COMPLETE PART I ON REVERSE SIDE

CPS INCOME PROVISION

1. Annual Gross Income means:
   a. The total income from all sources for yourself, spouse and dependent children for the last previous calendar year.
   b. If you are single, without dependents, your total income from all sources for the last previous calendar year.
2. If your Annual Gross Income was over the CPS $3600 gross income ceiling, please make your own financial arrangements with the Doctor in **ADVANCE** of service. In such cases the CPS payment will be applied to the physician's usual charge for services.
3. IF YOU ARE SELF EMPLOYED OR HAVE SALARY AND BUSINESS OR INVESTMENT INCOME:
   The total income from all sources for yourself, spouse and dependent children for the last previous calendar year, less your business expenses ordinarily allowable for income tax purposes.

IMPORTANT

PRESENT YOUR MEMBERSHIP CARD DURING FIRST VISIT SO THE ATTENDING PHYSICIAN WILL KNOW THE BENEFITS TO WHICH YOU ARE ENTITLED.

New Medical Rider: As a result of public demand for a medical care plan giving medical-services-in-the-hospital coverage to all family members alike, a new program, providing medical care while hospitalized, is being offered throughout the state for all new groups. Under this new plan, both the employee member and the family members will be entitled to medical services in the hospital, but the member will not be entitled to medical care outside the hospital. Existing contracts calling for medical care for the employee member outside the hospital remain in effect. C.P.S. stresses that it will now be more important than ever to examine membership cards to make certain of the type of medical benefits the member and/or family is entitled to. This will be clearly indicated on identification cards in the section which gives date of membership.

New Officers and C.P.S. Board Members: Three new members of the board of trustees of the California Physicians' Service were elected at the meeting of the C.P.S. Administrative Members in May. New board members are Dr. T. Eric Reynolds of Oakland, Dr. Frank A. MacDonald of Sacramento and Mr. Thomas Hadfield of San Francisco. At the board of trustees June meeting Dr. Lowell S. Goin was reelected president and Dr. H. Randall Madeley was elected first vice-president. Dr. J. Frank Doughty was elected vice-president replacing Dr. A. E. Moore, who had completed his term of service as board member. Dr. Henry L. Gardner was elected secretary, replacing Dr. Chester L. Cooley, who had similarly filled his prescribed term of office. Mr. Ransom Cook was elected treasurer and Dr. A. M. Meads was elected assistant secretary-treasurer. Other board members are Dr. Donald Cass, Dr. Kendrick Smith, Dr. Robertson Ward, Dr. John H. Rumsey, the Rt. Rev. Msgr. Thomas J. O'Dwyer and Mr. C. Ray Miller.

Opinion on Access to Hospitals' Records of Patients

On April 14, 1949, the California Attorney General rendered an opinion (No. 48/87) to the Director of Public Health of the State of California, in which he concluded that authorized representatives of the State Department of Public Health may examine the records of individual patients in hospitals. The opinion of the Attorney General on this matter is based on the theory that the Director of Public Health, or his authorized agents, has the right to inspect hospital records on any patients in order to enforce the regulations issued under Section 1411 of the Health and Safety Code or to see that hospitals are keeping records sufficient to make out a death certificate under Sections 10008 et seq. of the Health and Safety Code.

Referring first to the requirement concerning death certificates, Section 10008 of the Health and Safety Code requires hospitals and other similar institutions to keep records of personnel and inmates "sufficient and adequate for the completion of a birth or death certificate." Section 10375 of the Health and Safety Code lists the contents of a death certificate. This consists of the name, place of death, color, race, sex, marital status, names of survivors, names of parents, occupation of decedent, place of interment and medical certificates, etc. It is not required that the death certificate contain any of the matters that are normally in the average hospital record of the patients admitted therein. In other words, the death certificate does not need the diagnosis (other than the cause of death), nursing notes, medication orders or progress notes. Therefore, it is not necessary for the Director of Public Health to inspect the medical portion of a hospital record in order to see that Section 10375 of the Health and Safety Code is being complied with.

With reference to the requirement that hospitals must keep medical records as promulgated by the State Department of Public Health, these regulations have been promulgated under Section 1411 of the Health and Safety Code. This is the so-called licensing law of hospitals, and Section 1411 declares that the state department may promulgate, modify, remand, etc., "*reasonable rules* and *regulations* to carry out the purpose of this chapter, classifying hospitals and prescribing minimum standards of safety and sanitation in the physical plant, of diagnostic, therapeutic and laboratory facilities and equipment for each class of hospital." It is obvious, therefore, that the purposes of this Act are:

1. To license hospitals.
2. To classify hospitals.
3. To establish minimum standards of safety and sanitation in the physical plant.
4. To establish minimum standards of diagnostic, therapeutic and laboratory *facilities* and *equipment* for each type of hospital.

Under this section of the Health and Safety Code it is apparent that the State Department of Public Health exceeds its authority in issuing a regulation requiring hospitals to keep such specific medical records, including medication orders, progress notes, nurses' notes, diagnoses, laboratory reports, surgical records and condition of the patient.

Certainly if the department had the authority to make these regulations, then it would have the authority to inspect the records to see that they were being carried out. However, under Section 1411 the department does not have the authority, either expressed or implied, to require hospitals to keep such accurate and complete records on the patients.

Since the detailed records kept by hospitals are not required under Section 10008 of the Health and Safety Code, and since the Department of Public Health has no authority, statutory or otherwise, to

require them, it is our conclusion that the opinion of the Attorney General is in error and that the Director of Public Health has no more right to examine these confidential records than anyone else.

PEART, BARATY & HASSARD

Attitude Toward Position of Red Cross in Blood Banks

The apparent disagreement between the stand of the American National Red Cross, the Blood Bank Commission of the American Medical Association, and the Blood Bank Commission of the California Medical Association, is bringing nothing but chaos and ill feeling into a very important phase of American medicine. We, the C.M.A. Blood Bank Commission, believe this misunderstanding must be resolved immediately.

The following positive program should go far to bring peace to the troubled national blood bank situation.

We, the C.M.A. Blood Bank Committee, realize the remarkable blood donor job performed by the American National Red Cross during the last war. We believe the Red Cross can, and should lead in the establishment of blood banks where necessary. We have repeatedly set forth our belief in writing. The national program is tremendous in scope and requires expert guidance and control. Adequate blood coverage for all is a must for this nation. The Red Cross deserves special commendation for gathering together the organizational and technical staff for the realization of this humanitarian program.

To augment the financing, development, and erection of regional blood banks we advocate a plan making use of the Red Cross, the Institute of Health, the Public Health Department, the American Association of Blood Banks and that most important factor, the doctor. Each one of the above groups or individuals can serve a most useful purpose. United in harmony the national plan will succeed; disrupted by bickering, the plan must eventually fail. The Blood Bank program must and will succeed.

PROPOSED OUTLINE

1. The Red Cross should build, equip and finance blood banks where needed until said banks are self-supporting. Self-support to be achieved by non-profit service charge and the request for a donor replacement. Where the slight maintenance fee cannot be met by an individual recipient, the Red Cross could assume the charge. All publicity, volunteer work such as canteen, hostess, motor corps to be the function of the local Red Cross Chapter if said chapter can handle the work.

2. Standards to be set and maintained by the National Institute of Health with the local Public Health Department being allotted the task of maintaining said technical standards of blood procurement, processing, shipping, etc.

3. Operation of the bank would be under the active control of the local County Medical Society with adequate representation of the aforementioned appropriate groups. The bank would operate at cost in a true community blood bank.

Where blood banks are started under this set-up, reciprocity and integration can be readily carried out within the state and the nation. In disaster or war the American National Red Cross would logically assume control of the banks for the duration of the emergency.

Such banks would be required to turn over to the Red Cross a certain number of blood or plasma units for research and fractionation. The Red Cross is here able to play a tremendously important role. In view of its national scope, the Red Cross should assume leadership in furthering scientific research in all matters pertaining to blood and blood derivatives. If the Red Cross will subsidize qualified workers in universities, in blood banks, in the laboratories of biologic firms, etc., a tremendous upsurge of interest would be directed to the many problems of the entire blood therapy field. This we believe is the crux of the entire picture, and one for which the American National Red Cross is preeminently fitted. Blood derivatives made under such subsidy should also be dispensed at cost and not free.

This then is our plan. It is a big plan, and calls for big men with big thoughts. It is a plan which the American Medical Association, the American National Red Cross, the National Institute of Health and every doctor can endorse, work for and bring to rapid fruition. Such a plan could create, and start in operation all the blood banks that are required in the entire nation within two years. These banks would be urged to attain self-sufficiency as quickly as possible so that funds of the Red Cross could be diverted to the unexplored field of blood research. That field is practically virgin in its exciting possibilities.

Working together as a team the Red Cross and medicine could then give complete blood coverage to all at cost.

California with its constantly expanding non-profit, integrated blood bank system, is setting a standard for the nation. However, we would welcome aid from the Red Cross in the furtherance of the above suggested plan.

JOHN R. UPTON, *Chairman*
C.M.A. Blood Bank Commission

Alameda County Blood Bank

Five months' experience in its larger quarters at 354 Hobart Street, Oakland, has given the Blood Bank of the Alameda County Medical Association ample proof that the move from its original location at Alta Bates Hospital was well advised.

Coincident with the change to the larger, specifically designed quarters, the Blood Bank intake crossed the 1,000-unit mark in monthly volume. It has remained above that figure consistently, averaging 1,073 units per month for each full month from January 1 through May 31.

Such volume virtually was impossible with the limited facilities of the previous location. The bank had been opened in December 1944 with an anticipated "case load" of no more than 250 units per month, an estimate based on a pre-bank survey in mid-1944 when hospitals in the East Bay depended entirely upon the Irwin Memorial Blood Bank or upon walking donors.

By device and ingenuity, the Blood Bank staff was able to accept occasional intake loads up to 850 units per month at the old location. At present, however, its physical plant is capable of handling up to 3,000 units per month without inconvenience to the personnel.

During the past five months the Alameda County Medical Association Blood Bank has had no difficulty maintaining adequate reserves of blood of all types, including Rh negative. Employment of professional donors whenever needed, and for specific types of blood, provides the critical control factor, which is supplemented by the "two-for-one" replacement option.

The latter method, in addition to being the source of 20 per cent of the total monthly intake of blood, also is the Alameda County Medical Association's rebuttal to proponents of "free" blood. Blood, under the two-for-one method, actually costs the recipient nothing as donation of the second unit covers the cost of processing and delivery.

Goin Testifies Against Compulsory Insurance

Testimony of Dr. Lowell S. Goin before the United States Senate Committee on Labor and Public Welfare considering proposed compulsory sickness insurance legislation, follows:

I am a practicing physician and I happen to be President of California Physicians' Service, the voluntary health care plan of California. I had as well say at once that I am in complete opposition to this legislation. I oppose it as a physician because I am persuaded that its enactment would result in a great and continuing decrease in the quality of medical care available to our people. I oppose it as an American because I am persuaded that this type of legislation is one of the final steps on the road to State Socialism. In this opposition, I am confident that I am supported by the overwhelming majority of American physicians.

Specifically, my opposition is based upon five premises which I propose to state briefly, thereafter developing each one.

1. The assumption that the health of the American people is bad is a false assumption.

2. The assumption that the enactment of compulsory sickness tax legislation would be in the interest of the public health is totally unfounded.

3. Medical care is not the sole factor in the problem of health, and there are many things that government could properly do which would benefit the health of the public far more than the proposed legislation.

4. The cost of such plans, rather lightly passed over by the President and the Social Security Administrator, are totally unpredictable and almost certain to be extremely high.

5. Voluntary health care plans, which are truly in the American tradition, are giving good medical and hospital care to our people, and must be allowed to develop unhampered by bureaucracy.

Let me now consider these points each in its turn.

1. The health of the American people is bad, perhaps, but it isn't bad just because someone in the Social Security Administration says it is. Fortunately, it is a matter which may be investigated, and in which conclusions can be based on known facts rather than on emotional statements. Consider then, if you please, that the life expectancy at birth is steadily increasing, being now about 65 years for a male and 69 years for a female. It is materially less in Great Britain, and was still less in pre-war Germany. Both of these countries have long enjoyed the blessings of compulsory sickness insurance. The death rate from diphtheria per 100,000 of population, in the last year for which comparative figures were available, was 11.6 for Great Britain, 11.4 for Germany, but in the United States, with a benighted free enterprise system of medical care, it was less than 6.0. Why? Diphtheria is both preventable and curable; why didn't the government operated medical systems produce a death rate lower than ours? In the Public Health Reports for August 1946, the United States Public Health Service presents a table showing the death rate from tuberculosis in all countries. In the United States the rate was 47 per 100,000. In England and Wales it was 62. In France it was 137, and in Russia, 160. All of these except the United States have national medical care plans, but they seem to have been quite unable to equal the performance of the United States.

Some of the most lucid statements which are used to document our bad state of national health are found in Mr. Oscar Ewing's Report to the President entitled "The Nation's Health." Perhaps I may be permitted to digress for a moment, and to wonder what magical powers are inherent with civil servants of the Federal Security Agency, which makes them so omniscient in the problems of medical care, and why their opinions so greatly outweigh those of the 197,000 physicians of America whose entire lives have been spent in acquiring professional training to cope with these problems and in the actual coping with them. Mr. Ewing begins with a dramatic statement; a statement made to order for breadlines: "Every year 325,000 people

die whom we have the knowledge and the skills to save." Of these, he says, 170,000 die of communicable disease, and that we should be able to save 120,000 of them. This last figure seems to have been chosen at random, and no documentation is offered. As is not uncommonly the case, the figures are not exactly accurate. In 1945, 177,000 people actually did die of communicable disease, but in 1947 the figure had been reduced to 137,000. That the figure of 40,000 saved by our present system of medical care does not particularly bolster the case against that system is not mentioned. Perhaps this is purely coincidental. It is a fact that the death rate from communicable disease is the lowest in our entire history.

Mr. Ewing also says that we should be able to prevent 115,000 of the more than 600,000 annual deaths from cancer and heart disease. I am unable to ascertain the reason for the selection of the figure 115,000, and I suspect that it is a purely arbitrary selection. I don't know how many of the deaths were due to heart disease, but it is probably fair to assume that about two-thirds were. Is the implication that these people died because of lack of medical care a fair one? Of course it isn't. Actually, both heart disease and cancer are diseases of the latter decades of life. People eventually die of something, and the more people who live into these decades, the more will die of these diseases. If medical care is the problem, it is curious that the six states with the lowest death rate from heart disease were in the deep South, and that seven of the nine states with the highest rate were in New England. New England has more physicians, more hospital beds, more research centers, and more teaching institutions than the entire deep South. I repeat that it is most curious that the death rates should not fit the amount of medical care available.

Mr. Ewing complains of the shortage of physicians. One wonders why he believe that the enactment of a law bitterly opposed by physicians (physicians' sons are substantial part of the annual crop of new physicians), and one which experience in other countries has shown to degrade physicians, could possibly increase the number of physicians. I predict confidently that the enactment of this legislation will decrease the number of physicians produced annually, and that it will very materially lower the quality of the young men who enter medicine.

Another ill to be cured by compulsory sickness tax legislation is the inequitable distribution of doctors. There seems to be a vague and hopeful feeling that some magic inherent in this so-called social legislation will persuade doctors to leave cities, where medical schools and libraries are located; where hospitals and consultants can be found; and most of all, where a man can have the society of his peers, and go to remote hamlets where none of these things is available and where he can stagnate in intellectual loneliness. Doctors, like other people, locate themselves where they think they are most likely to succeed, and where they will be happiest. Why anyone should believe that enactment of a law will change these elementals is something of a mystery, but one which would be solved promptly if a paternal government were to direct physicians in choosing their fields of activity. Any such intent would be vigorously denied, of course, but the government of Great Britain has already assumed this right and has announced that more medical care in rural areas would be provided by paying a somewhat larger capitation fee in such areas and (n.b.) by forbidding doctors to locate in more populous zones.

2. The assumption that enactment of this legislation would be in the interest of the public health is unfounded. Fortunately for my argument (although unfortunately by other standards) we have a system of so-called compulsory health insurance in actual operation in the city of San Francisco. Set up by ordinance several years ago, it embraces more than 20,000 employees of the City and County of San Francisco. As a public duty, and as a noble experiment, the medical profession of San Francisco consented, almost to a man, to cooperate with the plan which is called "Health Service System." I see no reason to believe that a like system on a national level would function much differently than this "pilot" plan, and this is how it really works; this is what we may reasonably expect to happen once the plan begins to operate nationally. On May 28, 1947, Dr. A. S. Keenan, Medical Director of the "Health Service Plan," found it necessary to address himself to the physicians of San Francisco. He complains of over-use of the system, and urges great curtailment of the care given. The following are his own words: "People in general have more knowledge now on medical subjects. . . . It has brought about many unnecessary visits to the doctor to get treatment for trivial things. Such minor ailments could be treated as well by their home remedies as by their doctor." There, gentlemen, is a panel system in operation. The earliest, indeed the only early symptom of lung cancer is a trifling cough. Go home and take some cough medicine. The only early symptom of gastric cancer is a trifling indigestion. Take some soda. Next, the medical director complains of clinical laboratory and x-ray expense, and again I quote his words: "The people in general know little about the results that can be obtained from the help of laboratory tests or the x-ray examinations. Please, doctor, turn such requests aside. . . . It would seem that any physician, after taking a short history of his patient's case and making a routine examination will find that he can make a diagnosis without leaning so much upon the laboratories and the x-ray departments." Please note that early recognition of brain tumors requires laboratory study of the cerebrospinal fluid, and that early diabetes is recognized by the amount of sugar in blood. After complaining that it cost too much to hospitalize these unfortunate people whose pay checks were subject to compulsory deduction for the service, he says: "The members of the Health Service System, except in a few obscure cases, do not need any such extensive work." As is easily possible under the compulsory system, the director solves the problem

neatly, thus: "Hereafter no patient, except in an emergency case, will be entitled to hospital benefits under Health Service System coverage until authorization has been given by the medical director." There you have the panel system which our planners would like to institute; there you have medical care under compulsory health insurance. Personal interviews with British physicians who have been so revolted by the system that they have actually fled to the United States to start all over again, and correspondence with others who wish that they could flee, indicates that this is a completely fair picture of so-called compulsory health insurance benefiting the health of the public. If further evidence is needed, we might let Dr. Nathan Sinai furnish it. Remember that he is an able and ardent proponent of compulsory sickness tax legislation. I quote from his book *The Way of Health Insurance,* pp. 157, 158: "Contrary to all predictions, the most startling fact about the vital statistics of insurance countries is the steady and fairly rapid rate of increase in the number of days the average person is sick annually, and the continuously increasing duration of such sickness.

"Various studies in the United States seem to show that the average recorded sickness per individual is from seven to nine days per year. It is nearly twice that amount among the insured population of Great Britain and Germany and has practically doubled in both countries since the installation of insurance." To this he adds: "It seems to be a safe conclusion that insurance has certainly not reduced the amount of sickness." This surprises me, since I had naively assumed that the proponents believed that it would reduce the amount of sickness. Certainly, the words quoted comprise an excellent argument against this sort of medical care, although I doubt that Dr. Sinai meant them to be.

3. A sort of current custom is to use the terms "medical care" and "health" as if they were interchangeable—as though one were a synonym of the other. As a matter of fact, medical care is only a small part of the health problem—not even the most important part. Health consists largely in not being sick; medical care consists largely in an attempt to cure or alleviate disease. Nearly all—perhaps all—of the health legislation which has been proposed from time to time has been written by social planners, seldom, if ever, in consultation with physicians. Consequently nearly all it contains is wishful thinking and not too much reality. Too much confidence is placed in preventive medicine, too much earnest belief that periodic health examinations will prevent disease, and all the legislation evidences a complete failure to understand that preventive medicine simply has not yet attained the goals wished for. To cite a few of the problems: How shall heart disease (except that due to rheumatic fever) be prevented? What sort of health examination will be efficient in its control? How shall we prevent, or even recognize, early brain tumors? Shall everyone with a headache have encephalographic or ventriculographic studies? Shall we do gastrointestinal x-ray studies on everyone with indigestion, and, if so, where shall we obtained the skilled personnel? How are bone tumors prevented, and what periodic examination makes one aware of the pneumonia of next week? Medical care is, and will for a long time continue to be, the care of the sick, and this, I repeat, is only a fraction of the health problem. Some other fractions to which government might well turn its attention are sanitation, hygiene, health education, adequate diet, good housing, adequate clothing, working conditions and "patent medicine" control. And there are many others. If government is sincerely interested in the health of the citizen, why should it not suppress "patent medicine" advertising? Why should it not regulate cults and require that all who wish to practice the healing arts pass the same tests? Why should it not control radio publicity of nostrums, vitamins, and the like? This current legislation is attacking only a small segment of the health problem, and even if it were to accomplish all that its proponents claim, it still would not solve our health problems.

4. I shall refrain from elaborating in my statement that the costs of the proposed program are unpredictable and are likely to be extremely high. I am sure that there have been or will be witnesses much more able to cope with these problems than I, and I shall leave to them the discussion of the financial problems.

5. Voluntary health care plans have made a truly phenomenal growth. Thirty-two million people have Blue Cross insurance. Eleven million have medical care plan insurance. Twenty million more are covered by commercial carriers, and competition by Blue Shield plans has made them offer good comprehensive contracts. If permitted to do so, voluntary plans will ultimately cover a great majority of the American people. If there are rugged individualists who decline thus to protect themselves, must we compel them to do so? I seriously doubt if it is true that half the families in the United States are unable to pay for voluntary coverage. I feel sure that nearly all families can afford it if they are willing to assign a sufficiently high priority to medical care. In 1947 the American people spent three billion dollars for medical and hospital care, including drugs and services of irregular practitioners. They also spent 3.9 billions for tobacco, 9.4 billions for movies and recreation, and 9.6 billions for alcoholic beverages. Is it seriously argued that this budget could not be rearranged? And, moreover, aren't the same families going to pay for national compulsory sickness tax service? Will it be less painful to have the cost deducted from the pay check? Will the small self-employed person who wishes neither voluntary nor compulsory plan be happier when he is taxed for one?

Voluntary health plans will, if given the opportunity, do the job, and do it better than government controlled plans can do. These plans, which already include a very large number of persons, are in accord with our traditional emphasis on personal responsibility, prudence, foresight, and thrift.

They have an American dignity which is lacking in the regimentation of compulsory health insurance. They can be and are more economically administered, they can and do give better medical care, and they will be and are supported by thousands of physicians who are bitterly and unalterably opposed to government controlled medicine. In California we have made a good start. Our California Physicians' Service offers medical care at modest costs. Nearly 800,000 of our people have availed themselves of it, and appear to be quite satisfied with it. The Farm Security Administration had a medical care program for the rural indigent. California Physicians' Service took it over and gave better medical care for less money and to the satisfaction of those giving and receiving the care. California Physicians' Service has a contract with the State Grange providing medical care for nearly 100,000 farm people. These activities, which are duplicated in most of our states, are indications of how voluntary plans can meet the challenge, how they are meeting it, and how they will continue to do so with a steady and healthy growth if they are not crushed by the monster of bureaucratic control.

Supplemental Statement On "Lobbying" Charge

During recent weeks and months the American medical profession has been subjected to maliciously unfair abuse from certain advocates of compulsory health insurance, some of whom are officeholders in the federal government. Through vicious innuendo, false implication and outright distortion of fact, deliberate attempts have been made to undermine public confidence in the nation's doctors, and to make it appear that the American Medical Association is engaged in devious, unethical tactics in its opposition to national compulsory health insurance.

Very few members of Congress have been a party to this attempted smear. However, you gentlemen probably have heard or read some of the false charges. I believe that you know in your hearts that American doctors, by their very nature and training, would not take part in the questionable activities which have been implied in this scurrilous propaganda. Nevertheless, we need to clear the record with respect to these trumped-up charges.

The American Medical Association—openly, frankly, and honestly—is engaged in a national education campaign to give the people the facts about compulsory health insurance and the facts about voluntary health insurance. We frankly oppose the first and we enthusiastically favor the second. We hope and believe that the American people, given the facts, will agree with us.

In the best American tradition we are taking our case before the forum of public opinion. We are asking for a vote of confidence in the American medical profession and in the American medical system, the finest in the world. We are doing exactly what you gentlemen do at election time. We are using the same avenues of approach—the press, the radio, the speaking platform, pamphlets and leaflets, and all other accepted, ethical means of submitting our case to the people.

The Committee for the Nation's Health, the Physicians' Forum, and other groups favoring compulsory health insurance, are conducting a constant propaganda in behalf of it. For ten years or more, the Federal Security Agency and other government agencies have been spending unauthorized tax funds to thump the drum for socialized medicine. Now, however, when the American Medical Association finally strikes back at the distorted propaganda of the socializers and government payrollers, we suddenly hear unfounded and intemperate charges that The American Medical Association is invading Washington with a high-powered lobby and a huge slush fund.

These charges are absolutely false, and those who have been making them know they are false. As you gentlemen undoubtedly know, the Washington office of the American Medical Association is one of the smallest, most conservative legislative offices maintained by any of the national associations in the capital. It is staffed by men of unquestioned integrity, who are highly respected in Washington. Whitaker & Baxter, the public relations organization which is directing our national education campaign, has only one representative in Washington, and he is a press representative, not a legislative lobbyist.

The American Medical Association, in its national education campaign, is carrying its case directly to the American people in a grass roots crusade which we hope will reach every citizen in this country. By so doing, we doctors are simply exercising one of the greatest rights which Americans have as a free people—the right of petition as set forth in the United States Constitution. We are exercising that right not simply to protect the medical profession from degradation, but to protect the health of the nation.

The people have a right to know that government-controlled medicine means inferior medical care doled out according to bureaucratic regulations and rule books, ever-increasing payroll taxes, invasion of privacy and freedom of action, and destruction of the voluntary health insurance plans which provide good medical care at a lower cost than government ever could provide it.

In the final analysis, the American people, through their representatives here in Congress, will decide this issue. The objective of the American Medical Association national education campaign is to get the facts to the people. We want them to make their opinions known to their United States Senators and Representatives. We believe you want it that way.

If that is lobbying, it is lobbying in the finest American tradition, and every doctor is proud of his part in the program.

There is nothing secret or devious about this campaign. It is an open and above board public campaign on a vital public issue. The plan of campaign explaining the program has been distributed by the thousands throughout the country—not only

to doctors and medical societies but also to a wide variety of interested parties, including newspapermen and magazine writers. For your information, I am filing a copy of the plan of campaign with your committee. Nearly 14,000 copies of this have been distributed all over the United States. There is nothing in our program which is secret—and you may have copies of any material we are issuing simply by requesting it.

Yet, at least one radio commentator and one Congressman, in recent public utterances, have quoted from these widely-publicized materials, attempting to give the impression that they were revealing "shocking" information from "secret" documents. Apparently depending on the same unreliable source for their information, both men referred to the fact that American doctors intended to present their case in newspapers and magazines, and that doctors were urged to write letters to any Senators or Representatives who were their personal patients. These alleged "revelations," gentlemen, are nothing short of ridiculous. Since when is it a crime to submit material to newspapers and magazines? And since when are doctors deprived of the ordinary right of any citizen to write to the men who represent them in Washington?

If there is any need for a Congressional investigation of lobbying, it is for an investigation of the government lobby which has forced the American medical profession to strike back in defense of its good name. The Harness Committee reported to the House of Representatives in 1947 that at least six agencies in the executive branch of the federal government were using government funds in an improper manner for propaganda activities supporting compulsory health insurance. The Federal Security Agency alone has become a tremendous propaganda agency for government medicine.

It seems very strange to me that when I appear anywhere to speak on this subject, some representative of the Federal Security Agency often shows up in the same town, speaking in favor of government medicine. Who pays for this? Has Congress authorized the use of federal funds for these propaganda lecture tours? Is the Federal Security Agency usurping the rights of Congress, the regularly established legislative branch of the government?

As I mentioned a moment ago, government agencies lobbying for compulsory health insurance—some of them for ten years or more—have forced the American Medical Association to embark on its national education campaign. Although the great bulk of these campaign activities and expenditures do not constitute lobbying under the terms of the Federal Lobbying Act, Public Law 601 by the 79th Congress, in the opinion of our legal counsel, the campaign directors have registered according to the letter of that law. A report of expenditures for the first quarter of 1949 already has been filed, listing separately every item over $10.00. We invite the closest possible scrutiny of all reports and records.

More than half of the time, effort and money in this campaign will be used in affirmative, positive action, designed to aid in the development of the voluntary prepaid health systems. American medicine is far more concerned with solving a problem than with simply defeating a bill for compulsory health insurance. The ultimate, long-range objective of this campaign is to make the American people more and more health insurance conscious. We want them to know that sound protection against the costs of illness is available under existing voluntary health insurance plans, at reasonable rates far below the inevitable high cost of a compulsory, tax-supported program. We want the people to know the many different hospital, surgical and medical insurance plans are working constantly to extend their benefits. Already there is a tremendous demand in this country for voluntary health insurance. The greater that demand can be made, the quicker this problem will be resolved. The great need in America is not for compulsion but for a general realization by the people that health protection is an essential item which should be given its proper priority in the family budget, and which can be so budgeted without undue financial burden.

I think I am correct in saying that several members of this committee feel the same way. A number of you gentlemen have shown a definite interest in the great progress of voluntary health insurance, and you are sponsoring legislation embodying principles which we fervently support. We think you are on the right track to an American solution of this problem.

The American Medical Association national education campaign, by alerting the people to the wisdom and necessity of handling this problem themselves, is making a contribution toward the further improvement of our national health. We believe it also is performing a service of value to Congress, by making it unnecessary for you to levy new payroll taxes and launch this nation into a dangerous experiment in government medicine. Such an adventure would impair or destroy not only the American medical system but also our national financial stability. There are other, more sensible ways to solve our problems in medical economics.

Let's stop the small-boy name-calling. Let's settle this issue like adult Americans, using the best medical and economic tools that exist on the face of this earth.